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SECTION 38-71-290. Mental health coverage; definitions; treatment requirements; exceptions

(A) As used in this section:
(1) "Health insurance plan" means a health insurance policy or health benefit plan offered by a health insurer or a health maintenance organization, including a qualified health benefit plan offered or administered by the State, or a subdivision or instrumentality of the State, that provides health insurance coverage as defined by Section 38-71-670(6).
(2) "Mental health condition" means the following psychiatric illnesses as defined by the "Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV)", and subsequent editions published by the American Psychiatric Association:
(a) Bipolar Disorder;
(b) Major Depressive Disorder;
(c) Obsessive Compulsive Disorder;
(d) Paranoid and Other Psychotic Disorder;
(e) Schizoaffective Disorder;
(f) Schizophrenia;
(g) Anxiety Disorder;
(h) Post-traumatic Stress Disorder; and
(i) Depression in childhood and adolescence.
(3) "Rate, term, or condition" means lifetime or annual payment limits, deductibles, copayments, coinsurance and other cost-sharing requirements, out-of-pocket limits, visit limits, and any other financial component of health insurance coverage that affects the insured.
(4) "Settings" means either emergency, outpatient, or inpatient care.
(5) "Modalities" means therapeutic methods or agents including, without limitation, surgery or pharmaceuticals.
(B) A health insurance plan must provide coverage for treatment of a mental health condition and may not establish a rate, term, or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for access to treatment for a physical health condition in similar settings and treatment modalities. Any deductible or out-of-pocket limits required under a health insurance plan must be comprehensive for coverage of both mental health and physical health conditions.
(C) A health insurance plan that does not otherwise provide for management of care under the plan, or that does not provide for the same degree of management of care for all health conditions, may provide coverage for treatment of mental health conditions through a managed care organization if the managed care organization is in compliance with regulations promulgated by the director. The regulations promulgated by the director must ensure that timely and appropriate access to care is available, that the quantity, location, and specialty distribution of health care providers is adequate, and that administrative or clinical protocols do not prevent access to medically necessary treatment for the insured.
(D) A health insurance plan complies with this section if at least one choice for treatment of mental health conditions provided to the insured within the plan has rates, terms, and conditions that place no greater financial burden on the insured than for access to treatment of physical conditions in similar settings and treatment modalities. The director may disapprove a plan that the director determines to be inconsistent with the purposes of this section.
(E) To be eligible for coverage under this section for the treatment of mental illness, the treatment must be rendered by a licensed physician, licensed mental health professional, or certified mental health professional in a mental health facility that provides a program for the treatment of a mental health condition pursuant to a written treatment plan. A health insurance plan may require a mental health facility, licensed physician, or licensed or certified mental health professional to enter into a contract as a condition of providing benefits.
(F) The provisions of this section do not:
(1) limit the provision of specialized medical services for individuals with mental health disorders;
(2) supersede the provisions of federal law, federal or state Medicaid policy, or the terms and conditions imposed on a Medicaid waiver granted to the State for the provision of services to individuals with mental health disorders; or
(3) require a health insurance plan to provide rates, terms, or conditions for access to treatment for mental illness that are identical to rates, terms, or conditions for access to treatment for a physical condition.